

Patient Information	
Patient Name: Date of 3	Birth: Gender:
Primary Address: Town:	
State: Zip Code:	
Patient Email: Patient Cell:	
Parent/Guardian #1	Parent/Guardian #2
Name: DOB:	Name: DOB:
Address: ☐ Same as Above	Address: ☐ Same as Above
Town:	Town:
State: Zip Code:	State: Zip Code:
Phone Numbers: Home ()	Phone Numbers: Home ()
Cell: () Work: ()	Cell: () Work: ()
Marital Status:	Marital Status:
Email:	Email:
Employer:	Employer:
☐ Check if responsible for bills	☐ Check if responsible for bills
Primary Insurance	
Primary Insurance: Policy ID #	
Policy Holder Name:	DOB:
Secondary Insurance	
Secondary Insurance: Policy ID #	
Policy Holder Name:	DOB:
Billing Information and Consent for Pharmacy and Medication History	
I authorize payment directly to Pioneer Valley Pediatrics as	
insurance if necessary. YES	
I authorize Pioneer Valley Pediatrics to access pharmacy be	enefit managers/surescripts to obtain prescription
eligibility and medication history. YES NO	
Financial Obligation (PLEASE initial next to each statement)	
	y insurance company or if I cannot obtain my referral,
payment for all services rendered will be my financial responsibility.	
I understand that my insurance company may require me to pay a co-pay and it is due at the time of service.	
PVP adheres to insurance companies' ICD-9/ICD-1	0/CPT coding guidelines.
I understand that my insurance company may assess a co-pay during a preventative care appointment, if by	
their definition, the services provided exceeds a routine preventative well child visit.	
I understand that I must provide a 24 hour notice when cancelling or rescheduling, or may be subject to a \$25	
penalty. After three missed appointments I may be dismissed from the practice.	
SIGNATURE: Date:	
☐ Parent ☐ Guardian ☐ Patient	